Editorials

On the Nationalization of DRG Payments

AS THIS IS WRITTEN, it appears that the federal government is determined to move ahead with its plan to impose uniform national standards for the administration of its Medicare program. The diagnosis-related groups (DRGs) are already in place, and now the goal is to make the payments uniform nationwide to hospitals for these services. There has been remarkably little discussion as to whether this will even be workable, or of what might be the fallout in terms of patient care for the Medicare beneficiaries and others in various parts of the country. Nor has much thought been given to what might be the long-term effects of this particular federal initiative. It is already known that plans are being made by the government to include physicians' services in the DRG system, although little has been said so far about making the payments uniform nationwide to physicians for these services.

The DRG system is the most recent in a cascade of federal initiatives that have attempted to control or reduce the rising costs of health care. None of these has been very effective. Many were based on simplistic assumptions that proved to be false. The DRG system seems to have come into being more for the convenience of the government than any of its predecessors. Some kind of manageable national standards are probably essential, and certainly convenient, for the smooth and easy administration of a national program, particularly one that reaches as far into the infrastructure of society as does the Medicare program. But even so, it remains to be seen whether this will work any better than the earlier initiatives. It too may be based on a false assumption—in this case of a bureaucratic stereotype of a homogeneous nation and a homogeneous population. This we clearly do not have. It seems certain that national standards for Medicare payments will result in many inequities due to genuine regional differences, to say nothing of genuine differences in the needs of individual Medicare beneficiaries. It is not yet known to what extent these inevitable inequities will prove to be acceptable to society.

But for the long haul there may be an even more fundamental issue that has yet to surface. If payments for DRG services to Medicare patients are made uniform nationwide, then a segment of mainstream medicine will have effectively been nationalized. Are we really ready, as a nation, to move toward a single national system of mainstream health care, or would we prefer to retain our pluralistic system which allows for regional and individual variations and differences? Is there a chance that a bureaucratic imperative for administrative convenience at the national level might actually make this decision for us, even though no one may have planned it that way? It would seem that this just could happen.

To date, the only government initiative that has been really effective in controlling health care costs has been the systematic underfunding of government supported health care programs. The DRG system payments are now an obvious candidate for reduced funding, and this may be expected to occur as soon as it is clear that the program is a "success." Underfunding, whether in the public or private sector, is a powerful tool in health care today. In the final analysis, it produces de facto rationing of health care services. So far the poor have been getting the worst of it. Where the responsibility lies for deciding who gets what care is not yet clear. No one has yet stepped forward and claimed this responsibility. Elsewhere in this issue is a position statement, "On Rationing of Health Care," adopted by the Council of the California Medical Association. This at least places the issue on the table. Just as the bottom line in a financial statement shows the profit or loss, so the bottom line in health care will be the human profit and loss from de facto or planned rationing should this latter come about.

One can be uneasy about the nationalization of DRG payments. It is hard to see where this may lead, or in what way this federal initiative to cut costs will succeed, if indeed it does succeed.

MSMW

Cellular Basis for Injury and Repair in the Adult Respiratory Distress Syndrome

THERAPY FOR THE adult respiratory distress syndrome (ARDS) has continued to be supportive with an emphasis on mechanical ventilation, positive end-expiratory pressure (PEEP), careful management of intravenous fluid administration and therapy for the associated clinical disorder. Overall mortality from this disorder continues to be high, about 60%.[1] This dismal figure is not much different from the mortality figures available almost a decade ago when a National Institutes of Health Task Force on the Adult Respiratory Distress Syndrome recommended that intensive clinical and basic research be funded to increase our understanding of this devastating disease. Even though a better outcome has not yet been achieved, a number of clinical and experimental studies have advanced our knowledge of the syndrome.

Well-designed, prospective clinical studies have established that sepsis, aspiration of gastric contents and major trauma are the three most common clinical disorders associated with a high risk for the adult respiratory distress syndrome.[1] In addition, a controlled trial of prophylactic PEEP was completed recently in a group of patients at high risk for the development of ARDS.[2] Unfortunately, the results showed that applying 8 cm of water of PEEP before the development of acute respiratory failure did not prevent the occurrence of the disorder. Nevertheless, since the syndrome develops in most patients within 24 hours of the inciting clinical event,[2] it is important that these investigators were able to identify high-risk patients early enough in their clinical course so that treatment could be delivered before the onset of the fully developed syndrome. Similarly, the success of current and future clinical trials designed to test new treatment modalities will depend on identifying high-risk patients early in their clinical course. At our own institution, we have devel-